ČENE	RS FOR MEDICARE	& MEDICAID SERVICES	45	L	3/	2211	Ų	O	IMB NO	0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ONSTRUC	TION			(X3) DATI	(X3) DATE SURVEY COMPLETED	
		445491	B. WING_	B. WING						02/05/2014	
NAME OF	PROVIDER OR SUPPLIER		Ī	STRE	ET ADDRE	59, CITY, S	TATE ZI	PCODE	,		
MCKENE	REE VILLAGE INC		_	-	Lebano Mitage	N ROAD . TN 3707	76			•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	1	(EACI	OVIDER'S PI I CORRECT REFERENC DEI	IVE ACT	ON SHOULD HE APPROP	38 ···	(X5) COMPLETION DATE	
	AFTER SIGNIFICA A facility must cond assessment of a refacility determines, that there has been resident's physical opurpose of this sect means a major decresident's status that itself without further implementing stand interventions, that hone area of the resirequires interdisciplicare plan, or both.) This REQUIREMEN by: Based on medical refacility failed to confide the facility failed the facility failed to confide the facility failed the facility failed t	uct a comprehensive sident within 14 days after the or should have determined, a significant change in the or mental condition. (For ion, a significant change line or improvement in the it will not normally resolve intervention by staff or by ard disease-related clinical as an impact on more than dent's health status, and inary review or revision of the IT is not met as evidenced ecord review and interview, complete a Significant Change Data Set (MDS) for a change esident (#36) of twenty-three id:	F 27	N a s 44 F b d c c c c c c c c c c c c c c c c c c	Ackendras "facilities. ave subs deficienci ompliant Ackendrabstantia deficienci ubstantia def	nents mad i are not ar fute an agr ies herein. il compliar equiremen McKendr the actions	(herein de continue with the Villa corrected sieved state special continue with the continue continue with the for Lee Villa set for COMP	after references to be a 142 CFR I cong Term age has or I the allege ubstantial cified here astitutes ation of a that the allege with the action to and twith the attinue to real 142 CFR I cong Term age has taken in this parents.	red to in Part Care will ed in. lleged farch d do alleged main in Part Care cen or	3/22/14	
	Esophageal Reflux, Dementia, Anemia, and Joint Replacement Knee. Medical record review of the Admission Evaluation and Interim Care Plan dated November 12, 2014, revealed at the time of admission the resident was at risk for the development of pressure ulcers.			a V t	, comprei vithin 14 hat there	ty has and hensive as: days after has been a nt's physic	sessmer the fac a signifi	ot of a resi ility deter icant chan;	dent mines ge in		
ABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		· · · · · · · · · · · · · · · · · · ·	TITLE			. (X6) DATE	
·	Marsona ?	Morrison Exe	cutive	- 1	Deros	ten			<u>a) a</u>	100 Jac 14	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for runsing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event (D: U88011

Facility ID: TN1934

If continuation sheet Page 1 of 8

CENTER	KS FUR MEDICARE	& MEDICAID SERVICES			OI	<u>MB NO.</u>	<u> </u>
	NO BLANCE COORDINATE TO THE TOTAL MINISTERS IN THE PROPERTY OF		(X2) MUI A. BUILI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
<u> </u>	445491		B. WING			02/05/2014	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP GODE	-	
MCKENE	REE VILLAGE INC			1 `	1347 LEBANON ROAD HERMITAGE, TN 37076		
(VA) ID	STIMMARY ST	ATEMENT OF CEFICIENCIES	10	<u> </u>	PROVIDER'S PLAN OF CORRECTION	J.	Nei
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	(XS) COMPLETION DATE
	Medical record revilategrity Review da revealed the reside pressure ulcer on the ulcer on the ulcer on the left had been condition. Medical record revidated January 2, 20 POST (Physicians Treatment) form to (with) no Antibiotics further Infection related the president of November 2 resident did not have not indicate any decondition. Interview with MDS 4, 2014, at 2:40 p.m. confirmed a significant been completed or to reflect the decord the decord to reflect the decord the decor	tiew of the Weekly Skin ted December 4, 2013, and had developed one he right heel and one pressure el. iew of a Telephone Order 014, revealed "(change) Orders for Scope of DNR (Do Not Resuscitate) is Comfort Measures Only. No ated testing" view of the Admission MDS it with Assessment Reference 26, 2013, indicated the ve any pressure ulcers and did cline in the resident's Coordinator #1 on February in, in the computer room cant change of status MDS had do to reflect the pressure ulcers cline in the resident's condition. IENT/SVCS TO PRESSURE SORES prehensive assessment of a remust ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and a healing, prevent infection and		274	On or before March 22, 2014, the Hele Center Minimum Data Set (MDS) Coordinators, Licensed Social Worker Dietitian and the Activity Director with attend an in-service. The in-service we conducted by the Director of Nursing Designee and will include: Review of the regulation Review of the statement of deficiency Review of the plan of correct Conditions/changes in a resistants that trigger a significant change assessment Completing a significant change assessment Resident # 36 has and continues to reall necessary care and services. Resident Minimum Data Set assessment has becompleted. The MDS assessments of residents we have had an MDS assessment competed or after January 1, 2014 have been resto ensure a significant change assessment	ction ction dents e ceive dent #36 change cen ctor for ty t kly for ter. The t to the	3/22/14
	prevent new sores	from developing.			Completion date: March 22, 2014	i	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U88011

Facility ID: TN1934

if continuation sheet Page 2 of 8

CENTERO FOR MEDICARE & MEDICAID	SELVAIORS	 	U	<u> 1410 140. 0938</u> -0391
		(ULTIPLE CONS)LDING	(X3) DATE SURVEY COMPLETED	
	5491 8. WI	NG		02/05/2014
NAME OF PROVIDER OR SUPPLIER MCKENDREE VILLAGE INC		4347 LEI	ADDRESS, CITY, STATE, ZIP CODE BANON ROAD IAGE, TN 37076	
(X4) ID SUMMARY STATEMENT OF DEFICE PREFIX (EACH DEFICIENCY MUST BE PRECE REGULATORY OR LSC IDENTIFYING II	DED BY FULL PR	D EFIX AG C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 274 Continued From page 1 Medical record review of the Weel Integrity Review dated December revealed the resident had develop pressure ulcer on the right heel at ulcer on the left heel. Medical record review of a Teleph dated January 2, 2014, revealed 'POST (Physicians Orders for Scottreatment) form to DNR (Do Not (with) no Antibiotics. Comfort Meet further infection related testing' Medical Record review of the Adm (Minimum Data Set) with Assessed date of November 26, 2013, indicated in the resident did not have any pressurant indicate any decline in the rescondition. Interview with MDS Coordinator # 4, 2014, at 2:40 p.m., in the comp confirmed a significant change of not been completed to reflect the or to reflect the decline in the resident, the decline in the resident, the facility must ensure to who enters the facility without presides not develop pressure sores individual's clinical condition demot they were unavoidable; and a residence to promote healing, prevent new sores from developing	kly Skin 4, 2013, ped one nd one pressure cone Order ((change) pe of Resuscitate) asures Only. No chaisslon MDS nent Reference ated the e ulcers and did ident's 1 on February outer room status MDS had pressure ulcers dent's condition. Constrates that dent having y treatment and ent infection and	The that rece to p pre	14 483.25 (C) TREATMENT ARVICES TO PREVENT / HEA ESSURE ULCERS e facility has and will continue to a resident having pressure ulcers eives the necessary treatment and promote healing, prevent infection vent new ulcers from developing. or before March 22, 2014, Healthensed Nurses and Certified Nurses lattend an in-service, The in-service are reserved.	cnsure- s service a and a Center c Aides

FORM CMS-2567(02-99) Previous Versiona Obsolete

Event ID: U6BO11

Facility ID: TN1934

If continuation sheet Page 2 of 8

		& MEDICAID SERVICES	·····		0	MB NO.	0938-0391	
STATEMENT AND PLAN (STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			MULTIPLE CONSTRUCTION SUILDING			(X3) DATE SURVEY COMPLETED	
		445491	B. WING	<u></u>		02/	05/2014	
NAME OF	PROVIDER OR SUPPLIER			} ;	STREET ADDRESS, CITY, STATE, ZIP GODE			
MCKEN	REE VILLAGE INC		j	ł	4347 LEBANON ROAD HERMITAGE, TN 37076			
(X4) ID PREFIX TAG	(EACH DEFIGIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 314	by: Based on medical and interview, the fapressure relieving of resident (#36) of two pressure ulcers of the reviewed. The findings include Resident #36 was a November 12, 2013 Esophageal Reflux, Replacement Knee. Medical record review data one pressure ulcer on the Continued review of Review revealed "" Medical record review of the resided December 4, Boots at all times" Observation of the resident lying in bed lying on the mattres place.	record review, observation, acility failed to ensure a levice was in place for one oresidents reviewed for wenty-three residents ed: admitted to the facility on the work of the Weekly Skin and Joint of the Weekly Skin Integrity Skin Conditioneschar (dead a Telephone Order 2014, revealed "Waffle and one resident on February 4, 2014, resident's room revealed the with the right and left heel is without Waffle Boots in the tered Nurse #1, at the time of the series without waffle Boots in the tered Nurse #1, at the time of	F			ave ex have eving order. tor for ty t A) for one The	3/22/14	
	the observation con have the Waffle Boo	firmed the resident did not ts in place.				:		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U6BO11

Facility ID; TN1934

If continuation sheet Page 3 of 8

CENTE	S FOR MEDICARE	& MEDICAID SERVICES			. O	<u>VIB NO.</u>	<u>09</u> 38-0391
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		1		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445491	B. WING	_		02/	05/2014
NAME OF I	PROVIDER OR SUPPLIER			\$	TREET ADDRESS, CITY, STATE, ZIP CODE		
MCKENI	REE VILLAGE INC			4	347 LEBANON ROAD		
				H	ERMITAGE, TN 37076		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
= 000	_		{		E 242 462 4641 EDER OF ACCES	DATE/	
F 323			F	323	F 323 483.25(b) FREE OF ACCID HAZARDS/ SUPERVISION /DEV		3/22/14
	483.25(h) FREE OI		F:	323	. MAZARDS/ SUPERVISION /DEV	ICES	J. 22 / - 1
SS≂D	HAZARDS/SUPER	VISION/DEVICES			The facility has and will continue to	ensure	
	The decision of the				that the resident environment remain	s as free	
	I he tacility must en	sure that the resident			of accident hazards as is possible; an		
	environment temen	ns as free of accident hazards each resident receives	ļ		resident receives adequate supervision		1
		on and assistance devices to			assistance devices to prevent accided	nts	
	prevent accidents.				On or before March 22, 2014, Health		
			i		Licensed Nurses and Certified Nurse		i i
					will attend an in-service. The in-serv		
					be conducted by the Director of Nurs	sing or	
	This REQUIREMEN	NT Is not met as evidenced			Designee and will include:		1
	by:				Review of the regulation		
		record review, observation,			 Review of the statement of deficiency 		
	and interview, the fa	acility failed to provide			Review of the plan of corre-		
	of three residents w	ent falls for one (#28) resident eviewed for accidents of	l		Providing assistance during		
	twenty-three resider	sylewed for accidents of	i		toileting according to resident needs]
	The findings include				Resident # #28 no longer resides in t	ļ	
	Resident #79 was a	admitted to the facility on		.	facility.	ļ	}
į	November 11, 2013	b, with diagnoses including us, Urinary Tract Infection,			Random observations of residents wi require assistance with toileting and have a history of falls since January	who	
j					are being conducted to ensure reside		1
		ew of the Admission Minimum			receive assistance as needed.		
		ted November 18, 2013, at had severe impairment in		İ	Beginning March 22, 2014, The		}
		uired extensive assistance			Administrator or designee will monit		
ł		toilet use, and was only able]	continued compliance through Quali		
		nan assistance moving on and		1	Improvement audits (See Attachmen		ľ
	off of the tollet.	_			The audits will be completed weekly month and monthly for one quarter.		ļ
		ew of a Fall Risk Assessment 5, 2013, revealed the resident			Administrator or designee will repor QA/QI committee who will determine frequency of further monitoring.		
	was at fisk for falls,			ł	Completion date: March 22, 2014		1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U6BO11

Facility ID: TN1994

If continuation sheet Page 4 of 8

		& MEDICAID SERVICES	,		<u> </u>	OMB NO	. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NO PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
NAME OF		445491	B. WING	·		02	/05/2014
NAME OF PROVIDER OR SUPPLIER MCKENDREE VILLAGE INC				4	STREET ADDRESS, CITY, STATE, ZIP CODE 4347 LEBANON ROAD HERMITAGE, TN 37076	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X6) GOMPLETIÓN DATE
F 371	Medical record revior December 20, 2013 Residents bathroom transferring resident resident became we againstbody and salgns of Injury noted Medical record revial January 30, 2014, no bserved sitting on Certified Nursing As (resident's) light, (retoilet(no injury)." Observation on Febrevealed the resident resident's room. Interview with the DF February 4, 2014, at room confirmed the person assistance for fall on December 20 Interview with CNA fresident on the floor February 5, 2014, at nurse had assisted the when the resident pand found (the resident pand found (the resident was not to be sident was not to	sw of a Nurse's Note dated a, revealed "called to nby a tech. Tech was to to the toilet and states eak andleaned (resident) slid (resident) to the floorno i" sw of a Nurse's Note dated evealed "resident was the floor ofbathroom when sistant (CNA) answered sident) had attempted to ruary 4, 2014, at 1:30 p.m., at seated in a wheelchair in seated in a wheelchair in sirector of Nursing (DON), on a 3:10 p.m., in the conference resident was to have two or transfers at the time of the conference resident on the time of the conference on January 30, 2014) on-10:25 a.m., confirmed the he resident on the folor." ON, on February 5, 2014, at ofference room confirmed the left alone in the bathroom on January 30, 2014. DCURE,	F 37				

Event ID; U6BO11

FORM CM3-2587(02-99) Previous Versions Obsolete

If continuation sheet Page 5 of 8

Facility ID: TN1934

S FOR MEDICARE			O	MB NO. 0938-0391				
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
	445491	B. WING		02/05/2014				
		STREET ADDRESS, CITY, STATE, ZIP CODE 4347 LEBANON ROAD HERMITAGE, TN 37076						
(EACH DEFIGIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION				
Continued From pa	ge 5	F 371	F 371 483.35(I) FOOD PROCURE, STORE/ PREPARE/ SERVE	3/22/14				
(1) Procure food fro considered satisfact authorities; and(2) Store, prepare,	tory by Federal, State or local distribute and serve food		that food is procured from sources ap or considered satisfactory by Federal, or local authorities and that food is st	proved , State ored,				
by: Based on observational failed to store food failed to maintain a The findings including Observation with the February 3, 2014, a revealed: 1. The preparation debris at the back obeen cleaned in process and the contact with	tion and interview the facility under sanitary conditions and clean and sanitary kitchen. ed: de Dietary Manager on at 8:15 a.m., in the kitchen that table had food particles and of the table after the table had eparation for the lunch meal, tiner on the preparation table is stored ready for use, had iquid on the inside bottom in oking utensils. (8 pans ready for use had a greasy substance on ide of the pans. the reach in refrigerator nuce (kind unknown) ready for tion date of January 21, 2014.		Dietary staff will attend an in-service in-service will be conducted by the Executive Chef or Designee and will include: Review of the regulation Review of the statement of deficiency Review of the plan of correct Cleaning food prep surface Cleaning food prep surface Cleaning containers for stor utensils Cleaning pots and pans Labeling, covering and data items placed in the walk in cooler an in refrigerator Discarding items not used be expiration date The preparation table is clean and free food particles and debris. The square container on the preparate	ction s ing ng d reach ry the				
,	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFIGIENCY REGULATORY OR DE The facility must - (1) Procure food from the considered satisfact authorities; and (2) Store, prepare, under sanitary conditions and the findings included to store food failed to maintain at the findings included to maintain at the findings included to the findings included to the findings included to the findings included to the findings included the finding included the finding included the province of finding utensification of the containing and satisfaction and sustaining and satisfactions and satisfactions and sustaining and satisfactions and s	A45491 PROVIDER OR SUPPLIER DREE VILLAGE INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to store food under sanitary conditions and failed to maintain a clean and sanitary kitchen. The findings included: Observation with the Dietary Manager on February 3, 2014, at 8:15 a.m., in the kitchen	OF DEFICIENCIES F CORRECTION (X1) PROVIDER SUPPLIER A BUILDING 445491 B. WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to store food under sanitary conditions and failed to maintain a clean and sanitary kitchen. The findings included: Observation with the Dietary Manager on February 3, 2014, at 8:15 a.m., in the kitchen revealed: 1. The preparation table had food particles and debris at the back of the table after the table had been cleaned in preparation for the lunch meal. 2. A square container on the preparation table with cooking utensils stored ready for use, had food particles and liquid, food particles and liquid on the inside bottom in contact with the cooking utensils. 3. Five of five 18x8 pans ready for use had liquid, food particles and a greasy substance on the inside and outside of the pans. 4. A container in the reach in refrigerator containing a red sauce (kind unknown) ready for use, with an expiration date of January 21, 2014.	OP DEFICENCIES (X1) PROVIDER SUPPLIER 445491 D. WING RECVILLAGE INC SUMMARY STATEMENT OF DISPLECICIES (EACH DEFICIENCIES (EACH DEFICIENCY MISY REPECCIOED BY FILL REGULATORY OR LISC IDENTIFYING INFORMATION) Continued From page 5 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to store food under sanitary conditions and failed to maintain a clean and sanitary kitchen. The findings included: Observation with the Dietary Manager on Peturary 3, 2014, at 8:16 a.m., in the kitchen revealed: 1. The preparation table had food particles and debris at the back of the table rifer the table had been cleaned in preparation for the lunch meal. 2. A square container on the preparation table with cooking utensils stored ready for use, had food particles and diquid on the inside bottom in contact with the cooking utensils stored ready for use, had food particles and a greasy substance on the inside and outside of the pans. 4. A container in the reach in refrigerator containing a red sauce (kind unknown) ready for use, with an expiration date of January 21, 2014.				

FORM CMS-2567(02-98) Previous Versions Obsolete

Event ID: U8BO11

Facility (D; TN1934

If continuation sheet Page 6 of 8

		& MEDICAID SERVICES			O	MB NO.	0938-0391
人以口 ひにんい カモ うろううそうていろい しょうきょう しゅうしゅう しゅうしょう しゅうしゅう		1		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		445491	B. WING	<u> </u>		02/	05/2014
NAME OF I	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
MCKEN	OREE VILLAGE INC		i		4347 LEBANON ROAD		
			•		HERMITAGE, TN 37078	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFÉRENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	Continued From pa	ge 6 r revealed:	F	371 ·	greasy substance.	•	3/22/14
	date. 2. Two covered ca	uit stored uncovered and no			The red sauce with the expiration date January 21, 20914 was immediately discarded.	of	
	containers. 3. One covered ca	on the cover, trays or art with six trays of assorted f January 30, 2014 on the			Food in the walk in cooler is covered, labeled and dated as required. The juidated January 30, 2014 were immedia discarded.	ces	
	the observation con	lietary Manager at the time of ifirmed the food was not the kitchen was not clean or			The four inch pans are clean and free crusty debris. The sheet pans are clean and free of controls.		
	Observation on Februith the Dietary Exercised: 1. Twelve of twelve pans with black crustides and corners weach other ready for 2. Twenty-two of the sides and the sides a	wenty-two sheet pans stored ad black thick crusty debris on			debris. Beginning March 14, 2014 the Administrator or designee will monitor continued compliance through Quality Improvement audits (See Attachment The audits will be completed weekly a month and monthly for one quarter. The Administrator or designee will report QA/QI committee who will determine frequency of further monitoring.	y B) for one ; he to the	
	time of the observation of clean and sanita				Completion date: March 22, 2014 F 372 483,35(i) (3) DISPOSE GARI	BAGE.	ļ
F 372 SS=C	PROPERLY	SE GARBAGE & REFUSE spose of garbage and refuse	F3	372	OR REFUSE PROPERLY		3/22/14
	properly.	4. 9			The facility has and will continue to d of garbage and refuse properly.	lispose	

FORM CMS-2567(02-99) Previous Versions Obsoléte

Event ID: U6BO11

Fecility ID: TN1934

If continuation sheet Page 7 of 8

CENTE	40 FUR MEDICARE	E & MEDICAID SERVICES				<u>MB NO.</u>	0938-0391
	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AN OF CORRECTION 10ENTIFICATION NUMBER:		1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445491	B. WING			02/0	05/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 347 LEBANON ROAD		
MCKENE	REE VILLAGE INC				IERMITAGE, TN 37076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF CORRECTION OF C	₽E	(XS) COMPLETION DATE
F 372	by: Based on observatalled to ensure gardisposed of. The findings include Observation on Fewith the Dietary Exadministrator, at the kitchen revealed the amount of refuse Inbeverage containe an unidentified broaplastic covering the dumpsters. Interview with the Interview with th	ition and interview, the facility rhage and refuse was properly led: bruary 4, 2014, at 9;50 a.m., recutive Chef and the led dumpsters behind the large including uneaten food, empty rs, empty food containers, and which red substance inside of the ground surrounding the Dietary Executive Chef at the lation confirmed the facility had a garbage and refuse was	F	372	On an haffara March 22, 2014 Haolth	is free or for by for one	3/22/14
			1				

FORM CMS-2587(02-99) Previous Versions Obsolete

Event (D: U6BO11

Facility ID: TN1934

If continuation sheet Page 8 of 8